Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 ● Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-10-4715-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: LIBERTY INSURANCE CORP Box #: 28	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary Position summary not submitted.

Principle Documentation:

1. DWC 60 package
2. Receipts
3. Medical Reports
4. Total Amount Sought $355.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Copy of screen print showing payment issued to claimant for Rx paid out of pocket."

Principle Documentation:

1. DWC 60 package
2. Payment Screen

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
07/11/2009 – 02/03/2010	N/A	Out-of-Pocket Expenses	$355.00	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. Neither party submitted EOBs for the disputed dates of service.

2. This dispute relates to out-of-pocket expenses with reimbursement subject to the provisions of Rule 133.270 and 134.503.

3. The Insurance Carrier's response indicates reimbursement was issued on 09/07/2010 to the injured worker in the amount of $350.48 with check number 93791323.

4. Pursuant the Division Rule 133.307(e)(3)(A) the Division concludes that this dispute no longer exits. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
Texas Administrative Code Sec. §133.270, §133.307 and 134.503

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to $0.00 reimbursement.

		September 14, 2010
Authorized Signature	Auditor III Medical Fee Dispute Resolution	Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.